AMERICAN MEDICAL TIMES

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Surgeon to Bellevue Hospital.

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Chapter I.—MINOR SURGERY—Instruments, Union of Wounds, Dressings, Hæmorrhages, Blood-Letting, Counter-Irritants, Vaccination, Anæsthetics.
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Letter from Prof. Frank H. Hamilton, *Med. Director of the 4th Corps d'Armée, Army of the Potomac.*

Headquarters, Gen. Keyes' Corps,
Near Harrison's Landing, Va., July 22, 1862.

I have had the pleasure of looking over the "Hand-Book of Surgical Operations," by Stephen Smith of New York, and do not hesitate to pronounce it the best book yet published for the use of army surgeons; and as such I have recommended it to all the army surgeons I have met.

FRANK H. HAMILTON,
Med. Director 4th Corps.

Letter from S. Oakley Vanderpoel, M.D., *Surgeon General of the State of New York.*

State of New York, Surgeon General's Office,
Albany, June 4th, 1862.

Messrs. Baillière Brothers.

Gentlemen—I have examined as fully as my limited opportunities would permit the "Hand-Book of Surgical Operations" by Stephen Smith, M.D. I had waited with some interest the publication of the work, for I am confident the want of a similar publication has been felt by the medical staff of the volunteer force of our army. It seems to meet the exigency: the binding and size readily permit it to be carried about the person, and the plates anatomical and surgical are so simple and distinct as to readily recall not only the relations of parts, but define clearly the steps of an operation. The letter-press is clear, concise, and I should judge fully expresses the best established surgical opinions of the day.

Very respectfully your obedient servant
S. OAKLEY VANDERPOEL,
Surg. Gen'l, New York.

Letter from one of the Surgeons of the University Hospital, Nashville, Tenn.

University Hospital,
Nashville, Tenn., June 26th, 1862.

Your "Hand-Book of Surgical Operations" has reached Nashville. It is a beautiful thing, and perfect as far as it goes. The plates admirably illustrate the text. It is complete as a *military* hand-book of operative surgery, and is very highly spoken of by all the surgeons who have examined it.

From the "Boston Medical and Surgical Journal," June 19th, 1862.

This treatise was prepared, as the author says in his preface, at the suggestion of a number of professional friends who had been called from their usual avocations to act as regimental surgeons in the United States Army. They have felt the want of a manual of operative surgery at once portable, exact, up to the present stage of surgical knowledge, and fully and clearly illustrated. It is very evident that many of our professional brethren on whom the grave responsibilities of a military surgeon have fallen, could not be expected to represent in their own attainments at the moment, all that such a work should contain. Neither could they carry about with them a cumbersome surgical library. What was wanted was something to refresh their memories, in as small a compass as possible. Such a work Dr. Smith may fairly congratulate himself on having made. Its scope is limited to those branches of operative surgery which are of the most importance to the military surgeon, and yet, with the exception of gunshot wounds, the subjects treated of are liable to engage the attention of the surgeon at any time. The work is most copiously illustrated by excellent and intelligible wood-cuts, taken from the highest authorities, and the print is remarkably clear and legible—no small recommendation when we think of the dubious light of the tallow dips, by which it must often be consulted by those for whose special benefit it is intended. Its flexible cover makes it handy for use, and packable in any space large enough to crowd it into. We gladly recommend it as a most valuable companion to surgeons in the field.

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Bellevue Hospital Medical College,

City of New York. Second Annual Session 1862-3.

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EDWIN A. WARE, Bellevue Hospital, Janitor.

PRELIMINARY TERM.

The Preliminary Term will commence on Wednesday, Sept. 17, 1862, and continue to the beginning of the regular term, viz.: four weeks. In addition to daily instruction in the Bellevue and Blackwell's Island Hospitals, at least three Lectures will be given daily during the term, exclusively by members of the Faculty. The didactic instruction during this term will embrace the following subjects:—Surgical Affections of the Breast and Testes, by Prof. Wood; Surgical Affections of the Eye, by Prof. Sayre; Amputations, by Prof. Mott; Surgical Dressings, by Prof. Smith; Inflammations of the Uterus, by Prof. Taylor; the Symptoms, Signs, and Disorders of Pregnancy, by Prof. Barker; Uterine Therapeutics, by Prof. Elliot; Diet, by Prof. McCready; Comparative Anatomy, by Prof. Childs; Diagnosis of Diseases of the Heart, by Prof. Flint; Toxicology, by Prof. Doremus; Anatomy and Functions of Glandular Organs, by Prof. Flint, Jr.

REGULAR TERM.

The Regular Term will commence on Wednesday, Oct. 15, 1862, and end early in March, 1863.

During the whole of the Session the Student will have the opportunity of attending, at least, two Clinical Lectures daily. In addition to these, during the regular term, three Didactic Lectures are given on every week-day, except Saturday. The Didactic Lectures are so arranged as not to interfere with attendance in the Hospital wards. Ample time is allowed for accompanying the Visiting Physicians, Surgeons, and Obstetricians in their daily rounds, attending clinical lectures, witnessing surgical and obstetrical operations, and following private courses, without compromising in any degree the regular didactic instruction. Clinical and Demonstrative teaching constituting the great feature of this College, the arrangements are such as to render the immense resources of the Hospitals available to the Student to the fullest extent.

All the Lectures in this College are given either in the Hospitals or in the College building, situated within the Bellevue Hospital grounds.

The BELLEVUE HOSPITAL receives annually from TEN TO TWELVE THOUSAND PATIENTS, the average number of cases constantly under treatment during the winter being from EIGHT TO TEN HUNDRED. Cases of all descriptions, excepting only the eruptive fevers, are received. The annual number of births in the Hospital is about FIVE HUNDRED. The BLACKWELL'S ISLAND HOSPITAL, under the charge of the Medical Board of Bellevue Hospital, contains usually about ONE THOUSAND patients, a large proportion being affected with chronic diseases. This Hospital always contains several hundred cases of syphilis.

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The fees for all the tickets for the Session amount to $105. Tickets for one or any number of the seven departments of instruction may be taken out separately. The matriculation fee is $5. The graduating fee is $30. No additional fees are required for hospital tickets or anatomical material. Students who have attended two full courses in other accredited schools receive all the tickets for $50, exclusive of the matriculation fee. Students, after two full courses in this College, or who have attended one full course in this college, and one full course in some other accredited school, are required to matriculate only. Graduates of other schools, after three years, are required to matriculate only. Prior to the expiration of three years, they receive a general ticket for $50.

The requisites for graduation are the same as in other Colleges of this State.

Comfortable board and lodging may be obtained for from $3 to $5 per week. The *necessary* expenses at attending a course of lectures need not exceed $200, exclusive of travelling expenses.

Bellevue Hospital is situated on East River, between 26th and 28th Streets. The entrance to the Hospital is on 26th Street. Students, on arriving in the City, are requested to report at once at the College of Bellevue Hospital. The Janitor will be provided with a list of boarding-houses near the hospital, and will take pains to aid students in securing comfortable accommodations without delay.

Persons desiring further information are requested to communicate with the Secretary of the Faculty, Prof. AUSTIN FLINT, Jr., No. 74 Union Place, corner of 4th Avenue and 19th Street.

Geneva Medical College.—The Ses-

sion of 1862-63 will begin on Wednesday Oct, 1, 1862, and continue sixteen weeks.

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Fees, payable in advance.—Matriculation, $3. Tickets for the whole Course, $50. Graduation, $20. Demonstrator's ticket, $3. Anatomical material, $5.

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* R. Stone, M.D., will perform the duties of this department.

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COURSE OF LECTURES
ON
DENTITION AND ITS DERANGEMENTS.

DELIVERED AT THE
NEW YORK MEDICAL COLLEGE AND CHARITY HOSPITAL
IN THE PRELIMINARY COURSE.
SESSION 1860-61.

By A. JACOBI, M.D.,
PROF. OF INFANTILE PATHOLOGY AND THERAPEUTICS.

LECTURE XII.—PART I.

General Classification of Convulsions.—Dental Paralysis.—Name and Synonymes.—Views of Dr. von Heine.—Symptoms and Consequences.—Etiology.—Dr. von Heine's Reasons for its being a Spinal Affection.

THE remarks made in my last lecture on the various causes of convulsions, and the influence of some irritation of the dental nerves in bringing them on, enable us to classify their etiology in the following manner. Convulsions result from

I. Direct irritation either
  1. in the peripheric course of motory nerves, or
  2. in their origin in the central organ.
II. Irritation of sensitive nerves, the grey substance of the nervous centres being the joining link between the sensitive and the motory nerves,
  1. consciousness being entirely excluded—reflex—convulsions proper.
  2. consciousness being more or less excluded; the brain is the proximate seat.
III. Anomalous nutrition of the nervous tissue
  1. in the peripheric nerves,
  2. in the brain,
  3. in the spine.

In this latter class the morbid symptoms are either permanent, or temporarily induced by either
  1. direct irritation, or
  2. irritation of and through the sensitive nerves, or
  3. voluntary action.

In this classification we cannot include the sometimes permanent contraction of the muscles which does not at all depend on any morbid condition, or irritation, of the nervous system or a single nerve; nor those which, it is true, are brought on by either direct or reflected irritation, or by voluntary action, but at all events require a morbid condition of the muscular substance.

Although the above classification is thoroughly physiological and rational, you perceive at once the difficulty of bringing every case of convulsions occurring in practice, under its proper head. It is entirely impossible to know enough of the history of the patient and of the immediately preceding irritations in every given case, to determine its character. But this much is easily understood, from what I have said, that the large majority of cases of convulsions are of but a symptomatic character, and further, that the proximate causes may be very various and numerous. Therefore it follows, that the practice of explaining attacks of convulsions occurring during dentition, that is, a period of life where a large number of unwonted influences are brought to bear upon the unresisting infantile organism, by nothing but the irritation of the dental ramifications of the fifth pair of cerebral nerves—is entirely one-sided and unjustified. It is true, however, that the distinction between the various possible causes requires more pathological knowledge and diagnostic ability than mere dictatorial airs and the common practice of wantonly cutting down into the gums of a child affected with some unexplained ailment. Always be aware that convulsions are no disease, but the symptom of some morbid alteration or irritation, and that these alterations and irritations are very numerous and various, and that of those very numerous and various irritations, the protrusion of a tooth under more or less unfavorable circumstances, may be one.

Now, after you have reviewed the principal points of the etiology of convulsions, and found out with me the possible connexion of dentition and convulsions, it remains to speak of the connexion of the same process with paralysis, as occurring in young children. Most, but by far not all, of the cases of paralysis in infantile age are observed at the period of dentition, that is, about or after the middle of the first year. Inasmuch as the age in which this affection was principally observed, struck the minds of observers most, it was called *infantile* paralysis; because its etiology and nature were not understood, it was baptized *essential*, as we are pleased to name everything the nature of which we do not know, essential or specific; and as it was generally observed at the time of dentition, and thought to depend on some difficulties in the protrusion of teeth, it was called *dental*. Thus the terms, essential, infantile, dental paralysis, so common in both practice and medical literature, are synonymes.

Infantile paralysis, although not a common, is not an unfrequent disease, and an important one both for its practical bearings and its scientific interest. I shall try to explain, as far as possible, its etiology and nature; but before that I shall have to review the principal views held by the leading authors on our subject. Among the first ranks Dr. von Heine, with his book on *Spinal Infantile Paralysis*, who, in the attempt to provide an anatomical foundation for the peculiar symptoms of the disease, takes all the genuine cases of infantile paralysis for spinal affections. But the description of the characteristics of the disease, as found in his work, fully coincides with the teachings of other authors, and with what observations every one of you will have to make in his own future practice.

Essential, dental, or infantile paralysis, runs its course in two distinct stages, the first of which is very short, so short indeed sometimes that it is not at all or hardly noticed. An infant exhibits some slight symptoms of fever in the evening, is put to bed, sleeps more or less, sometimes quite well, and is paralysed when taken up. Sometimes, however, the initiatory symptoms are more serious, high fever, congestion, cerebral irritation, symptoms of meningitis, or of "difficult dentition" being present. Patient is restless, screams in paroxysms, the eyes are half open in the interrupted sleep. Vomiting, diarrhœa, or the symptoms of rheumatic fever are sometimes observed. Or the first symptoms of an eruptive fever, with or without convulsions, or an attack of convulsions depending on one or more of the above mentioned causes, isolated or repeated, will be observed. The child becomes tired, quiet, and is paralysed. Generally the lower extremities are affected, sometimes an upper one at the same time; frequently a single lower extremity, without an affection of the arms; in some cases paralysis is so local as to affect single muscles only. The urinary bladder and rectum are sometimes debilitated, but never paralysed for a longer period. The whole number of paralytic cases recorded by Dr. Heine amounts to 192. Of these, 158 were such as he comprehends under the head of spinal infantile paralysis. Of these were—

	Males.	Females.	Total.
Paraplegia	17	20	37
Hemiplegia	18	16	34
Partial paralysis	44	40	84

Paralysis of one arm was observed in two cases; it was never cured, and was never complicated with paralysis of any other organ. Paralytic lordosis was observed in a single case.

The second stage, that is, fully developed paralysis, is as long as the former is short. Vital turgor is diminished, skin and muscles are flabby. The sensitive nerves are not at all or but little affected; where there is in the beginning paralysis of the trunk and arm it disappears, with the ex-

ception of a weakness of the muscles of the back sufficient to give rise to paralytic scoliosis. Where the two lower extremities are affected, one will gradually recover its mobility, and sometimes nothing will remain of the original disease but the paralysis of some muscles, principally the peronæi. There is, however, seldom a thorough improvement after the first four, or eight weeks: then the temperature sinks, feet and muscles become atrophic, the bones decrease in both length and thickness. The muscles will shorten, the tendo Achillis being the first to contract; in consequence of repeated attempts at locomotion, deformities will at last show themselves. Lateral curvatures of the vertebral column are very frequent: a bluish tint of the skin, frostbites, and ulcerations are the results of the diminished efforts of the heart and arteries. Bowels operate slowly and insufficiently in many cases; menstruation is not interfered with, and in a single case was even observed at the early age of twelve years. Neither mind nor senses are affected. The renal secretion is more or less normal; some have found a superabundance of phosphate of lime at the time of the commencing atrophy of the muscles, but not all the authors have obtained the same result. The diseases peculiar to early age do not prove particularly dangerous, so that some patients have been known to reach an advanced age. Hutin records the case of a man who died at forty-nine years.

A year or two after the appearance of paralysis, deformities begin to develop themselves, particularly in the lower extremities. Their principal forms are the paralytic varieties of talipes varus, valgus, equinus, calcaneus, contractions of the hip and knee-joint, retrocurved, inverted, and everted knee. They depend on the want of equality as far as the degree of muscular paralysis is concerned; the completely paralysed muscles having lost their power, while their antagonists are still active to a certain degree. Thus talipes equinus is the result of contraction of the tendo Achillis which is not counteracted by an antagonist; the same affection combined with paralysis of the peronæi muscles produces talipes varus; paralysis of the anterior and posterior tibial muscles: talipes valgus; paralysis of tendo Achillis: talipes calcaneus. In a similar manner, in hemiplegia and paraplegia, where the extensors of the legs are paralysed, contraction of the knee is brought on; and adduction of the thigh to the pelvis is the result of paralysis of the extensors of the thigh. Of the mentioned deformities t. equinus comes usually first, t. varus next, t. valgus third, and lastly t. calcaneus. The differential diagnosis between this affection from cerebral and spasmodic hemiplegia is simple and easy; for in this latter muscular retraction sets in with the acute cerebral affection. Paralysis of the arm generally gives no rise to contraction and deformity, as mostly both flexors and extensors are equally affected, and no antagonistic muscular action is called forwards by any disturbance of the equilibrium.

The etiology of infantile paralysis appears simple enough, if we are to believe the assertions of Dr. Von Heine. The nervous centres undergo a rapid physiological development during the first years of life; in this period infantile paralysis is principally observed. Therefore there is a great liability to alterations of the brain and spine, in grave cases of difficult dentition, or severe exanthematic fevers, in consequence of hyperæmia, congestion, and irritation. The usual results of these processes are cerebral and spinal meningitis, with serous or bloody transudations, followed by pressure and paralysis. The age of such children is a very predisposing element, as about this period of life those pathological changes are of common occurrence; a further predisposition is attributed by the author to the very healthy, robust, and vigorous constitution of those generally affected, also to the presence of general symptoms of fever (also in other diseases), high temperature, congestion, convulsions, fright, screaming, and vertebral pain in such children as are sufficiently advanced to explain their sensations. Thus the author sees the cause of infantile paralysis in spinal effusions, in some perhaps in extravasations. The former supposition he considers as founded on the fact, that (by resorption, he says) a complete paralysis of the trunk and extremities will very generally disappear, to a certain extent, during the first period of the whole process. As to the results obtained by post-mortem examinations, they are very few indeed; for as infantile paralysis has in itself no tendency to terminate fatally, there are very few examinations on record. At all events, however, there are a few, which by their pathological remnants proved the spinal origin of the cases. As for other results found in the dead, they give no clue to the anatomical cause of the affection. Such, for instance, is the atrophy of the limbs, especially the muscles, and the degeneration of the latter into adipose, and in one instance even cellular tissue. Nerves and arteries require, it is true, a longer time, and have less tendency to become atrophied and degenerate, but they have been found to be so.

According to Dr. Heine, we need not wonder at the frequency of spinal diseases of local character. It is sufficiently explained by its normal hyperæmia, and its functional character. Lesions of the entire spine, however, are very rare; but Prof. Schiff has proved by experiments, that the affection of a limited part of the medullary substance of the spine may result in complete paralysis. Generally a lesion of the right side will be followed by paralysis on the right side, and *vice versâ*. The action of the sensitive nerves may remain normal, a circular pain only being felt in cases of mere compression of the spine, depending on dilatation of the blood-vessels, and effusion, or certain other diseases of the membranes. This circular pain even may be absent when the anterior lateral parts of the spine are affected. In cases of very superficial and partial affections of the spine, paralysis will be partial in a corresponding degree.

Original Communications.

REMARKS ON ALBUMINURIA,

MADE BEFORE THE NEW YORK ACADEMY OF MEDICINE.

By A. CLARK, M.D.,

PROF. OF PRACTICE AND PATHOLOGY.

(*Continued from page 46.*)

The other case has occurred more recently, and has not been reported. It was in a gentleman, sixty years of age, who had for six years been struggling with diabetes. He had been to a considerable extent his own physician, though when he thought he needed advice he applied to Dr. Cheesman. I saw him with Dr. T. M. Cheesman. A considerable portion of the six years he had made himself quite comfortable by observing the rules laid down by Camplin. About three or four weeks before his death, he was seized with slight rheumatic symptoms, and then a severe pain in the direction of the right sciatic nerve. The urine had fallen to a low specific gravity, had lost its diabetic characteristics, which, however, soon returned, and being examined for albumen, did not contain any, but did contain casts in abundance. Occasionally a specimen was found in which there was albumen, but the quantity was always small. The sugar soon returned, and continued, so that the urine was often both saccharine and albuminous. He died sinking away into a sort of semi-lethargy, easy, and without pain. I cite these two cases because I do not know of any similar ones that have been recorded. Dr. Smith stated to me that some were referred to by Camplin, but I have been unable to find them. At all events the cases are interesting, and were new to me. There is now under observation a gentleman from one of the western cities suffering from diabetes, in whose urine I discovered casts a month ago. His physician has been made acquainted with the fact, and if the case terminates as these have done, we shall have the advantage of noticing earlier the character of the disease, and marking its pro-

gress better; and if the termination is a favorable one, we may learn that the presence of casts is not always indicative of bad consequences.

In this connexion I may observe, that in one instance at least, diuresis or diabetes insipidus has been converted into Bright's disease. A patient, who was very well known in Bellevue, having been there five years ago, and the object of considerable attention on account of the large quantities of insipid urine that he passed, was at my last term of service at St. Luke's Hospital, a patient there. He has now albuminous urine, œdema, in a word, all the signs of confirmed and incurable Bright's disease.

Two of the most interesting relations of the affection under consideration are those noticed in scarlet fever and in pregnancy. During the whole course of scarlet fever after it is fully formed, I am led to suppose, from a limited observation, that the urine can be found to be albuminous in all the grave cases. I suspect it will be found to contain albumen after the second or third day of the eruption, and though I have not continued my observation in such manner as to speak with confidence in regard to its duration, it certainly in many cases is found again in about a fortnight from the termination of the eruption, and its appearance is marked by very well-known symptoms. Now, we have a train of symptoms and lesions which have not usually received the name of Bright's disease, still the changes that take place in the kidney are the same as those which occur in the large white kidney. In post-mortem examinations the kidney has been either large, or has been distinguished by the appearances that mark the white kidney. Casts are almost always found in this albuminous urine, and they are of the coarse variety, frequently loaded with large granules and the nuclei of kidney cells, and not unfrequently a considerable number contain blood. Such casts are found very frequently from the large kidney. The symptoms during life and the observations after death ally this affection so closely to the coarse forms of Bright's disease that we are compelled to recognise the relations and seek for a common cause. It is then not wrong to call it acute Bright's disease, although Bright did not include it in his classification. I said a little time ago that the consideration of this form of disease is to my own mind one of the most gratifying, because it is in the great majority of instances cured. In other words here is a form of kidney disease, advancing to great disorganization, produced by a specific poison, aided in many instances by the effects of cold air upon the surface of the body. The causes are at length removed by the co-operation of nature and art. The disorganized kidney then slowly returns to its normal condition, resumes its natural function, and health is restored. And while we can cure a disease which we cannot distinguish from Bright's disease except perhaps by its severity, I cannot but hope that the time will come when we can cure the chronic affection. Nearly the same remark may be made of the albuminuria of pregnancy, however produced, whether by the sympathetic relations between the nerves of the uterus and those of the kidneys, or by pressure of the gravid uterus upon the aorta below the emulgent arteries, by some influence which obstructs the return of blood from the kidney, or by some peculiar state of the blood, as in scarlet fever. No matter what may be the cause, the fact is sufficiently well established, that in a certain proportion of pregnancies, beginning sometimes at a pretty early period, the urine does become albuminous, the whole body is more or less œdematous, casts are found in the urine, and it is also well known that after parturition this same affection continues sometimes for one, two, three months, and then the patient gets well. So far as my observation goes, there are but few instances of this kidney of scarlet fever, and this of pregnancy, which take the chronic form of disease. I can refer to a few pregnant women who have become chronically affected, and who finally died, but they are very few. The great majority get well. Here, again, the cause onceremoved, the patient recovers.

There is still another relation of Bright's disease that is of very grave importance—it is its connexion with chronic disease of the heart. Here I suppose we are likely to lose everything that can be strictly denominated nervous influences, and I suppose if we seek an explanation we must look for it in the circulatory system—still I am not sure that this is a settled fact. The co-existence of Bright's disease and heart disease has been long recognised; the question that has remained debatable is, which is the cause of the other? I believe it is the more common opinion that the kidney affection produces that of the heart. This is not my conviction. On the contrary, it seems to me that I can cite a hundred instances in which the heart disease was recognised long before any symptom of kidney affection appeared. In most of these cases kidney affection has been looked for, and for a variable time not found, and no very grave symptoms were recognised until these organs had become involved. I do confidently believe, whatever may be the exceptional facts, that, as a rule, the heart is first diseased, and in some unexplained way induces the kidney complication. You may remember, Sir, a patient we saw together, and whom I had seen many months before with heart disease. I stated to him that he had heart disease, and that he would be able to attend to his business, if no disease of the kidney should show itself. There was no symptom of such disorder then, and the urine was perfectly healthy. You will remember how deeply affected with Bright's disease he afterwards became, and how soon he died. I have in my mind a great many instances of this sort where I have said to patients with heart disease years before their death—take care of yourself, live prudently, avoid alcoholic drinks and exposure to cold (as if I had said, don't get congestion of the kidneys), and nobody knows how long you may be comfortable; but let these organs become involved, and you can count the time you have to live in months, perhaps in weeks.

(To be Continued.)

THE OPHTHALMOSCOPE IN MILITARY MEDICAL INSPECTION.

By HENRY D. NOYES, M.D.

The medical man who inspects recruits for the army, finds need of no little tact and skill to detect diseases concealed, or feigned, by those who desire either to obtain a bounty or to escape a draft. Many men have already found their way into the ranks of our army, whose imperfect eyesight unfitted them for duty, and in the coming conscription some may basely seek exemption by pretending to be thus disqualified. I propose to show how complete are the means of diagnosis and detection now at command in this important part of military medical inspection, viz. as to the actual condition of the recruit's eyesight. I do not allude to external diseases of the eye, but to the defects which lie concealed behind the iris, or are pretended to exist.

It is also needless to speak of dilatation of the pupil by the clandestine use of mydriatica: in doing this, the unsuspecting person little thinks that he is only preparing the way for the more complete discovery of his fraud, by laying open more extensively to the search of the ophthalmoscope the essential parts of the organ of vision.

It is not difficult to decide upon the degree of vision of the willing recruit. He must satisfy certain tests:—be able to see print of a certain size at a standard distance. It is not his capacity of reading fine print which should be tested, but his vision of distant objects—as reading a sign across the street, and discerning objects visible to those who are known to have good vision.

One point under this head merits notice, viz.—Should strabismus be a necessary disqualification? I readily assert that it should not—contrary to the rule usually laid down. It should lead to a more critical examination of the vision, but the actual state of the vision, and not the squint, should

be the ground of the decision. Each eye must be examined separately, and if each can see to a distance clearly, the squint ought not to exclude the recruit. It often happens that in strabismus one eye is imperfect, and therefore squints. If this is the left eye, the soldier can take aim with his musket; if it be the right he seldom can, and may, therefore, be rejected. To rigidly exclude from the ranks all who have squint, would deprive ourselves of some valuable soldiers.

I had the satisfaction last summer of adding a soldier to a New York regiment, who had been discarded by the inspector on account of a very conspicuous divergent squint. The young man came to the Eye Infirmary for operation, determined to enter the ranks if the defect could be removed. I found he had perfect vision in each eye. By two operations upon each external rectus muscle, I completely cured the blemish. He could read ordinary print with both eyes simultaneously. He afterwards presented himself for a final visit, dressed in Zouave uniform and about to start for camp.

The case calling for exact discrimination by the medical man is when, on account of alleged obscure vision, a soldier seeks discharge or a conscript exemption. If the disability be genuine, justice to the service and to the person requires his exclusion; if it be feigned, his baseness demands exposure. The entire absence of external signs of ocular disease is of no account in deciding upon its presence. We are not, however, compelled to rely only upon the person's assertions: a careful use of the ophthalmoscope, by one who has had sufficient practice, will settle the question. A case in point is as follows: A man living on Long Island, aged 27 years, came to me desiring a certificate of disability for military service, on account of nyctalopia. This, he said, he had had for many years, and a sister had the same disease. At night his vision was so bad as to make it dangerous for him to go out. In dim light he could see objects only by looking directly at them, his lateral vision being extremely bad. To external appearance the eyes appeared normal, the media clear, the pupil active, iris natural, etc.

On viewing by the ophthalmoscope the interior of the eye, the eccentric parts of the retina were seen stippled with pigment in a kind of network or tracery; dots and lines, spider webs and bird tracks scattered about, and especially noticeable along and upon the twigs of the retinal vessels. The central portion of the retina was free from such deposit. This is the disease known as Retinitis pigmentosa, of which Donders, Müller, Graefe, Wedl, and others, have written. It is incurable. Of course the man is entitled to exemption from draft.

But the ophthalmoscope is not the only means at the service of the inspector. He may not feel confident of his diagnostic skill with the instrument. For a case of feigned dimness of vision it is indispensable; but if a man pretend falsely to have one eye blind, the cheat may often be quickly detected by the use of a prism. This is a suggestion of Prof. Graefe. Lead him into a dark room where there is but one lighted candle. Do not let him look at the light until a prism, say of 10° angle, shall be put before the "blind eye." Ask him how many lights there are, and he may say "two," when his deceit is exposed. If he do not get tripped in this way, hold the base of the prism towards the temple, and bid him look steadily at the light to be sure that there is but one. By looking fixedly for a minute or two, he will really come to see but one image; the muscles of the eyes instinctively adjusting themselves to effect this object. Then suddenly remove the prism, and the reputed blind eye will be seen to quickly assume another position in looking at the light. At the instant when the prism was withdrawn the man saw double images, then the eye turned inwards to recover single vision, proving the fact of vision in the eye in question. Another crafty device is to rotate the prism, and the man may assert that one of the lights is being moved upwards, downwards, etc., as the base of the prism is being turned downwards, upwards, etc., in a manner contrary to the direction in which the light appears to go. The physical illusion may thus disclose the moral deceit.

The possession of but one blind eye, especially if that were the left, might not exclude a man. If he profess to be *wholly* blind, the ophthalmoscope is the detective, but a man must have considerable medical knowledge and tact to avoid condemning himself under a critical cross-examination of his symptoms.

Another disease often assumed, or concealed, is near-sightedness. When it is falsely pretended to, it may be almost certainly exposed by requiring the man to read fine print held closer to the face than is possible for normal eyes. The ophthalmoscope, however, gives accurate testimony upon the refractive powers of the eye as well as upon the state of the tunics. By it one can recognise the near-sighted, the normal, and the far-sighted eye. These classes are distinguished, not by their capacity of seeing near objects, but of discerning distant objects. The near-sighted eye can see at a distance, only by aid of *concave* glasses; this is myopia. The normal eye requires no aid from the optician. The far-sighted eye needs *convex* glasses; this is better called hypermetropia, was formerly called hyperpresbyopia; the latter name is now going out of use.

In discovering these anomalies, we do not use the double convex objective lens, which furnishes the inverted image, but use only the ophthalmoscopic mirror, and seek to get an upright image of the fundus oculi. To do this the pupil must be widely dilated, and the power of accommodation annulled, therefore the solution of atropine must be of strength of gr. iv. ad ℥j., or a weaker solution be used several times during an hour.

In a normal eye, when its accommodation is entirely at rest, the retina lies exactly at the focus of the transparent media. The images of objects at a distance will be formed distinctly upon it, because the light comes from them nearly in parallel lines. Conversely, light proceeding from the retina out of the eye, will, after passing through the media, be transmitted in parallel lines. This is a well known law in optics. If an observer be so placed as to catch the light issuing from the retina, and if he adjust his own eye for parallel rays, he will get an image of the retina. If he bring his eye to within half an inch of the patient's, and still maintain the adjustment of his own vision for distant objects, he will see not only retinal vessels, but all or nearly all of the optic nerve at once. If, however, he withdraw to twelve inches' distance, he can see but a small bit of a single vessel, and that more magnified than before. As his distance increases the field contracts in area, and the magnifying power increases. At the distance of twelve inches no useful inspection of a normal eye can be had by the upright image; usually there appears only a reddish glare, with no distinct details.

How is it with the myopic eye in its refractive phenomena? I purposely omit mention of important lesions found in a large class of myopic eyes, which are so because of posterior staphyloma of the sclerotic. I deal only with the dioptric peculiarities. In these eyes, the retina lies beyond or behind the principal focus of the ocular media. Light coming from distant objects forms an image in front of the retina, and casts upon it only circles of dispersion, because the rays impinge upon it after having crossed each other.

What is the behavior of light coming from the retina out of the pupil of a myopic eye? Reference to a simple law of optics will show, that representing all the media by a single lens, and knowing the retina to be situated at a point further from the lens than its principal focus, the rays of light after transmission will be made more or less convergent, will ultimately cross each other, and at the point of crossing will form an image of the retina. This image may be at two inches or thirty inches distance from the patient's eye. The further the retina lies from the lens, the nearer will be the situation of the image, and the more intense the myopia; while vice versa, the slighter

the myopia, the more nearly does the retina approach its true position in the principal focus of the lens, and the more distant the image becomes, because the emergent rays converge less rapidly. If this image is formed at a greater distance than twenty-four inches it will be difficult of observation, because a normal eye requires to be six inches removed from the image for its perception; this added to twenty-four makes thirty inches as the total distance between the patient and observer, at which distance the illumination by the mirror becomes too feeble. Therefore in cases of moderate myopia, those less than twenty-four, the observer, to get a view of the fundus, must use a concave glass to make the convergent rays parallel or divergent. If he place himself at twelve inches' distance he would need a concave lens for cases of myopia of six or seven. At this distance he will only see small parts of retinal vessels; they will appear clearly defined, and the apparent size less than in a normal eye. At twelve inches' distance, the visible field is necessarily small, and no proper exploration of the retina is in this way possible, but sharpness of definition and facility of discovery of the retinal vessels of a moderately myopic eye will arrest the observer's attention; the eye cannot be of normal refraction. To prove the abnormity to be myopia, let the observer approach to within an inch, or, if possible, closer to the eye; instead of getting a larger field and better view as in a normal eye, he would be able to see nothing at all. This settles the diagnosis of myopia, but does not determine its degree. This can be approximated to by finding how strong the concave glass needs to be to see the fundus from a given distance, say of three inches, the observer's visual power and seeing distance being known, and the concave glass found by trying one after another. In an admirable treatise upon the Ophthalmoscope, by Dr. Adolf Zander (Der Augenspiegel, seine Formen, und sein Gebrauch. Leipzig und Heidelberg, 1862), he gives a table for finding the exact concave glass needed when the patient's myopia is known, and also the observer's seeing distance. I aim only to show how in a simple but decisive manner the existence of myopia may be proved or disproved.

Again, there are phenomena peculiar to refraction in a hypermetropic eye which are easily appreciable to the ophthalmoscope. In this case the retina lies in front of the principal focus of the refracting media; it lies too near to the lens. Distant objects would form their images at a point behind the retina, and by intercepting their rays before they cross, it receives only diffused light. Tracing the course of the rays as, when proceeding from the retina, they pass out of the eye, we find that because they come from a situation nearer to the lens than its principal focus, they continue divergent in a greater or less degree, according to the degree of hypermetropia. But in such a case the fundus ought to be easily visible, because we are accustomed to see all objects by diverging and parallel pencils of light. Such is the fact. At twelve inches you see the retinal vessels as clearly as in a decidedly myopic eye, much more so than is ever possible in a normal eye. As you approach more closely the extent of field increases, the sharpness of outline and amplitude remain the same. Eyes like this require convex glasses for distant objects; extreme illustrations of this defect are patients who have been operated for cataract.

En resumé of these distinctions between normal refraction, myopia, and hypermetropia, in their ophthalmoscopic adjudication—the pupil being widely dilated and the observer supposed to have normal vision.

At twelve or eighteen inches' distance:—in the normal eye vessels are indistinctly visible, the field small, only a small part of a vessel visible, and that highly magnified. In the myopic eye, where the degree is moderate, nothing is seen. If the degree be intense vessels are sharply defined, the field large, the amplification slight. In the hypermetropic eye, vessels are well defined, the field small, amplification greater.

At two inches' distance:—in the normal eye, vessels become distinct, the field larger. In the myopic eye, nothing is visible of details. In the hypermetropic, the field is larger, vessels distinct, amplification about the same.

I may not conclude these remarks without allusion to a well known method of discerning myopia. This is by the use of concave spectacles. In the Austrian military service the rule adopted is that those persons are unfit for service, who, with concave glasses of six inches focal length, can make out print or characters half a line high and of corresponding breadth, at less than six inches' distance from the eye. In this way a judgment may be rapidly made, and those who are highly myopic easily eliminated. The print or characters alluded to are equivalent to what we know as "pearl," which is No. 2 of Jæger's scale. It is impossible for a normal or hypermetropic eye to read this with concave six at less than six inches distance. A myopic eye which requires a glass —12 or —14 may do it: those less than this cannot, those greater than this will. This test excludes those who are anxious to prove their myopia, but does not detect a slight degree of myopia in one who seeks to enter the army. For this purpose, the ophthalmoscope becomes necessary.

Lastly, a case of amblyopia is sometimes mistaken for an abnormal state of refraction, because such persons sometimes use spectacles. They sometimes use convex glasses for reading, simply as magnifying glasses. I have also seen a person with very dim sight because of advanced choroidal disease, use a deeply concave glass to see distant objects, such as the numbers of houses and the names of streets. Inspection with the ophthalmoscope would at once explain the true state of the eye, what the amblyopia depended upon, and also if it were combined with real abnormities of refraction.

278 Fourth Avenue, New York, August 18, 1862.

CASES

TO SERVE IN THE HISTORY OF THE RELATION WHICH EXISTS BETWEEN

PUERPERAL FEVER AND EPIDEMIC ERYSIPELAS.

By M. PIHAN-DUFEILLAY,

INTERNE DES HOPITAUX, MEMBER OF THE SOCIETES D'ANTHROPOLOGIE ANATOMIQUE-MEDICALE D'OBSERVATION.

[Translated from the French of the Union Medicale, by Dr. P. F. C Deslandes, of New York.]

(*Concluded from* p. 88.)

The ordinary coincidence of puerperal fever and traumatic erysipelas is admitted. No matter whether these two diseases act over each other and mutually engender each other, or whether the wounded and lying-in women be the victims of two accidents totally distinct, having the same origin; the essential point is to admit this identity of the cause, which so many chemists acknowledge without owning it clearly. Now, it constantly happens that one same cause produces only effects of the same kind, except the secondary modifications which its effects undergo, in proportion to the qualities and properties peculiar to the subjects which are submitted to its action. In virtue of this principle our lying-in women, and those out of the puerperal state, having been exposed to the same cause of infection, the latter must have acted on their organism in the same way, but with a rapidity proportioned to their predispositions, their debility, their force of resistance, the energy and integrity of their nutritive functions. Therefore, did we see our lying-in women debilitated by the fatigues of gestation, the efforts and the pains of labor, the hæmorrhage of delivery, attacked within the twenty-four or forty-eight hours after confinement. On the contrary, erysipelas made its appearance at the end of five, six, seven days, and sometimes much later in those women in good health, and consequently more able to resist longer external impressions. But this morbid influence once felt, the anatomical

modifications which accompany it, having neither constancy nor fixed place of election, it will follow that these manifestations will be expressed by the lesion of the organs whose vitality is excited, and which their irritation predisposes to become the seat of serious changes. In the lying-in women it will be the lymphatic vessels and veins of the uterus, the uterus itself and peritoneum—hence, puerperal fever with its complications, so frequent, of lymphangitis or of uterine phlebitis, of metritis and peritonitis. In the wounded, in whom the venous and lymphatic system is injured, also, it will be lymphangitis, erysipelas, and purulent absorption. On the subject whose skin, hardly excoriated, presents but few irritated lymphatics, it will be lymphangitis and erysipelas. If we view the local lesion in this way, although we recognise the anterior existence of the general affection, which alone, to tell the truth, constitutes the disease, we find the explanation of its most marked symptom, the erysipelatous eruption which, in the women submitted to our observation, had always for a starting point a slight solution of the continuity of the skin.

The examination of the general symptoms, the study of the really serious phenomena which characterized the disease, rendered the prognosis uncertain, and brought on the death of one of our patients, fully corroborate the opinion we have just stated of one same morbid cause producing two effects of the same kind, which are distinguished only by some of their accessory phenomena. These secondary phenomena, superadded, to a certain extent, to the principal disease, and whose intensity could change the symptoms proper to the primitive disease, are peritonitis and its own proper symptoms in puerperal fever, inflammation of the lymphatics, tumefaction of the face, sympathetic cerebral reaction, lesion of the mucous membrane of the larynx, or erysipelas. Apart from special symptoms which inflammation of the peritoneum and that of the skin and lymphatics of the face bring with it, we find in puerperal fever, as well as in our erysipelas, a collection of symptoms so peculiar, so complete, so characteristic, that it must have struck all those who at that time followed the clinic with any attention. The patient is suddenly taken with chills, rather violent; fever appears; diarrhœa supervenes spontaneously or only at the end of thirty-six hours; the breath is fœtid, the tongue dry and fuliginous; there is extreme depression, then immobility and prostration, an indifference disproportioned to the intensity of the local accidents; dyspnœa appears within twenty-four or forty-eight hours, without appreciable anatomical cause, as if the globules of the blood had lost, as was shown by Vogel in true puerperal fever, the property of complete hæmatosis; there is until death some nocturnal subdelirium without agitation, with clearness of the intellect during the day; lastly, the pulse remains all the time very quick and small. Does not this picture represent the summary of the three cases of erysipelas given above, as well as a short description of the pathognomonic symptoms of the typhoid form of puerperal fever, one of the most grave varieties of this disease, and that to which most of our lying-in women fell victims? Add to the above symptoms, for some, abdominal pains, tympanitis, vomiting of green matters, and a contracted facies (facies grippé) testifying to the peritoneal complication; for the others the erysipelatous redness and swelling of the face, the difficulty of speech, the absence of abdominal symptoms, and you will have the complete description of the phenomena presented by our patients attacked with erysipelas, and those affected with puerperal fever. Let us compare this erysipelas, which yields to none in intensity, with simple erysipelas, and even with bilious or mucous erysipelas, which come nearer to it, and we shall find there neither vomiting, nor frequent delirium, nor the slow pulse, nor the diarrhœa, nor even the constipation which characterize this form; moreover, we will meet with symptoms which do not belong to simple erysipelas, so that if we wished to compare with the symptoms of another disease the phenomena which succeeded each other in the erysipelas whose history we are now giving, it would not be among the other varieties of inflammation of the skin, but only in typhoid puerperal fever that we would be able to find a unity of comparison.

One more remark on the eruption, the march of which presented something unusual in the way in which the erysipelatous growths (poussées) succeeded each other, invading several times the same parts, reappearing when the symptoms seemed to be about to disappear, and prolonging the disease for such a long time that the only means of obtaining the cure of some of our subjects was to send them out of the ward. These relapses, mentioned as rare by classical authors, are referred by them to the bilious and mucous varieties of erysipelas, in which the general symptoms predominate, and which are assimilated to malignant fevers by most physicians. Some have gone further, and have, basing themselves on observations, given this symptom as constant in erysipelas due to the miasma of puerperal fever. For us who are ignorant of the value of this symptom, we will simply state that it was striking in those cases we have observed, and that these facts agree fully with the examples cited, and the opinions expressed on this subject.

Post-mortem furnished us unfortunately with signs of but little importance for the solution of the problem which engages our attention. The characteristics of the erysipelas and puerperal fever remaining yet to be found, the lesions we have observed have quite a secondary value from which it is impossible to arrive at a precise conclusion. However, they are rather favorable than contrary to our opinion; the spleen was softened and hypertrophied, the blood, thick viscid, darkish, coagulated in diffluent clots, characteristics already observed in some erysipelas, and which belong to this disease as well as to typhoid affections and puerperal fever. The peritoneum was injected, but we think this lesion supervened during the last twenty-four hours of life: therefore we mention it, without daring to interpret it.

One word more of the change observed in the mucous membrane of the larynx at the autopsy. Whatever might have been its origin or nature, sure it is that we have observed it in two other cases, where the patients died of infectious erysipelas contracted in the surgical wards, where it remained among the wounded. One, suffering from a sprain, was observed by us at the Hôtel Dieu, in the service of Mr. Robert, where he died of spontaneous erysipelas of the face, with symptoms analogous to those met with in the women at St. Louis. The other died at the same period in the surgical wards of La Charité; and we examined the larynx presented to the Société Anatomique, by Mr. Guéniot. Is it not singular that identically the same lesion should have been met with in two subjects who died from the epidemic erysipelas common to the surgical wards, and in a woman placed outside of any condition of traumatism and crowding, but submitted to the influence of puerperal miasma? Notwithstanding the importance of such comparison (rapprochement) it would not of itself suffice to settle so difficult a question; and it would be venturing too far to base oneself on the similitude of these three alterations to conclude as to the identity of the cause that produced them—and hence, as to the unity of the principle of puerperal fever, traumatic erysipelas, and spontaneous erysipelas. Therefore, do we only point it out; it belongs to men better qualified than we to deduct the consequences, and to indicate the relations which unite all these affections.

Although the facts we have given seem to leave but little doubt as to their etiology and nature, we strictly confine ourselves to the *rôle* of observer. Having related what we have seen, we will take good care not to discuss a subject so embarrassing, and which our masters treat so differently. We wished to give to our cases only the value of an exact information, and we leave to others the care of interpreting them.

The death of one of the most illustrious of the members of the French Academy of Sciences is announced—of M. de Sénarmont.

Reports of Hospitals.

NEW YORK HOSPITAL.

AMPUTATIONS OF THIGH AND OF FOREARM—SYME'S OPERATION—DISLOCATION OF THIGH—VARICOCELE TREATED BY LIGATURE—REMOVAL OF FRACTURED END OF TIBIA, ETC., ETC.

[Reported by JOHN T. KENNEDY, M.D., Acting House Surgeon.]

(*Concluded from page 92.*)

IV.—*Amputation of Thigh for Osteo-Sarcoma of Leg.*—Andres Cator, æt. 19, private 48th New York Volunteers, was admitted July 18th. He stated that seven months previously he had first noticed a swelling on the outer side of right leg about its middle, which prevented him from being on duty for two or three days at a time; but that recently he had been incapacitated for any work whatever. The tumor had increased rapidly within a few days, so that at the time of admission it extended from the ankle nearly up to the knee-joint. The circumference of the swelling at its most prominent portion measured seventeen inches. Sharp pains were complained of in the tumor, from time to time, ever since its first appearance. There was no hereditary predisposition to cancer. On the 21st inst. a consultation was held, as a result of which the thigh was amputated at the juncture of the upper and middle thirds. The flap method was adopted, the edges of the wound brought together by sutures and adhesive plaster, and the whole covered with cold water dressings.

An examination of the tumor by the microscope showed it to be unmistakably malignant. It involved the whole of the shaft of the fibula, the tibia being free from the deposit.

Recovery took place without any complications.

V.—*Amputation of Thigh for Gunshot Wound of Knee.*—Patrick McGowan was wounded at the battle of Fair Oaks, eighteen days previous to admission. The ball entered at the outside of the left patella, and lodged, as was supposed at the time, in the popliteal space. An incision was accordingly made in that situation, but failed to discover the ball. At the time of admission the wound in the popliteal space had healed, while at the entrance of the ball there was an ulcerating surface about the size of a twenty-five cent piece. In the course of the third or fourth day after admission the knee became very painful and much swollen. This condition of things gradually increased, and pus accumulating in the joint an incision was made on the fifteenth day, giving vent to a profuse discharge. During all this time the strength of the patient had been very much depressed. Continuing to run down, and life being in jeopardy, a consultation held on the twentieth day, advised an operation as a *dernier ressort*. The thigh was amputated at the junction of the middle and lower thirds by a circular incision. In order to give the patient every chance to recover, the operation was performed in the ward, and he was immediately after placed upon his bed.

The wound in the severed limb was then examined, and was found to have been inflicted by a buckshot, which had opened the joint and buried itself in the outer condyle of the femur.

Immediately after the operation the patient seemed to rally very satisfactorily, and remained in a promising condition for several hours, at the end of which time he began to sink, and died in the course of twenty-four hours after the operation.

VI.—*Crushed Hand—Fracture of Radius—Amputation of Forearm—Purulent Infection, etc.*—Frank Bowman, æt. 42, a German tailor, was admitted June 4th, and was unable to give any satisfactory account as to the manner in which he received his injuries. His friends, who accompanied him, however, stated that a short time before, while lying asleep on a railroad track, he was run over by the train. His right hand was found badly crushed at the radio-carpal articulation, the wound communicating with a fracture of both bones of the forearm near their middle. The vascular supply was completely cut off from the hand below, it being cold and insensible. Besides these injuries there was also present a simple fracture of the left radius near its carpal extremity (Colles'). There was not much shock.

The left forearm was placed on a straight palmar splint, and secured in position by strips of adhesive plaster. The patient was then etherized, and the right forearm was amputated near its middle by the double flap operation. The tissues in the neighborhood of the wound were dark-colored, but were possessed of a sufficient vitality to promise good union. The general condition of the patient was very good for several days, when a rather extensive burrowing took place, followed by purulent infection. Abscesses formed on the head and in the joints, causing the patient gradually to sink. He died of pyæmia about two months after admission.

VII.—*Crushed Foot—Syme's Operation.*—W. S. Maynes was brought to the hospital on the 26th of June, suffering from a severe and extensive wound of the foot which he received in a saw mill. It was badly crushed in a lateral direction, the toes and metacarpal bones being crowded promiscuously together. Syme's operation was performed as soon as the patient recovered from the shock, and the recovery has been perfect.

VIII.—*Dislocation of Femur on Dorsum Ilii—Reduction by Reid's Method, with the aid of Anæsthesia.*—Pat'k McGowan stated, that on the 7th of June, immediately before admission, he was caught between the buffers of two railroad cars, one striking the left hip and the other the knee of the same side. On examination the head of the femur was found luxated on the dorsum ilii, the foot being everted and the limb shortened three and a half inches. The reduction was effected under the influence of chloroform by Reid's method without any difficulty, and the two limbs afterwards bandaged together in an extended position. On the 21st the patient was allowed to get up, and on the 27th was able to walk out of the hospital on crutches.

A second case of dislocation of the femur was also treated in the same service, but the head of the bone was displaced in the ischiatic notch. The same method of treatment was adopted, and in ten days subsequently the patient was able to walk about.

IX.—*Varicocele Treated by Ligature.*—Thos. Dolman, æt. 21, a native of Ireland, and a carriage maker, presented himself for treatment of varicocele on the 12th of June. About a year previous he first, accidentally, noticed that the scrotal veins on the left side were enlarged. This he at once referred to the frequent and violent exertion which he was accustomed to make. The presence of the disease became in time, to him, a great source of annoyance and discomfort, and he at length decided to submit to an operation for its removal. He accordingly gained admittance into the hospital for this purpose. The scrotum was found very lax and redundant, and the scrotal veins were very much enlarged, presenting the usual tortuous appearance. On the 16th the patient was etherized, when the bundle of veins were carefully separated from the vas deferens and ligated in three places, the skin between each ligature and its vein being divided. A similar operation to this was performed during the same month and with the same result.

X.—*Fistula in Ano, Treated by Ligature.*—A case of fistula in ano was treated by ligature with a very satisfactory result. The patient, a merchant, 30 years of age, had suffered from a fistula to the right of the anus for upwards of a year, when he placed himself under treatment. A curved eyed probe was introduced into the opening armed with a stout silk ligature, which was brought out by the anal opening and simply tied. The patient was then allowed to leave. The ligature gradually separated, and when he reported himself in the course of a fortnight or three weeks, the wound had healed and he was entirely cured.

XI.—*Compound Fracture of Leg—Sawing off of Lower*

End of Upper Fragment.—Adam Edwards, æt. 35, a native of New York, coachman; was thrown from a horse, receiving a compound complicated fracture of the right leg a short distance above the ankle. The wound in the soft parts was for the most part situated anteriorly, and the lower end of the upper fragment of the tibia protruded through the wound in such a manner as to render it impossible to reduce the fractured portions. This end was sawn off to the extent of two inches, when the limb was brought out in a straight position and properly adjusted in a fracture-box. The patient is now doing well, new bone forming from the periosteum which was left, and the promise is that there will be very little shortening.

This case is interesting only as an example of conservative surgery. In times gone by such an injury would have been a sufficient excuse for immediate amputation.

There has been performed a very interesting operation of removal of a tumor from the shoulder of a patient who had previously suffered amputation at that point, but as it is the intention of Dr. Briddon, who had charge of the case previous to admission, to give all the points in detail, it is but due to him that he should not be anticipated.

Progress of Medical Science.

RECENT DEATHS UNDER CHLOROFORM.

The terrible frequency of deaths consequent upon the administration of chloroform for surgical purposes is a matter which cannot be regarded with indifference. Two deaths are now to be recorded, both under somewhat noteworthy circumstances.

John Emanuel Hill, of Norwich, aged sixteen years, was one of these unhappy persons. From the evidence given at the inquest, and the remarks of the coroner, we gather that the lad was the subject of disease of the bone of the great toe, the result of injury. He was placed under chloroform by Mr. Willis, not a qualified medical man, in the presence of Dr. F. C. Holland and Mr. Crawford Bell, both qualified practitioners, but said to entertain homœopathic views. Dr. Holland stated that the patient was a very healthy young man, that from a careful prior examination he was satisfied there was no disease which would render the inhalation of chloroform dangerous, that a very small quantity of chloroform was administered, and that the patient died in five minutes from the commencement of the inhalation. We pass over the statement of Dr. Holland, that from the first he considered that *nothing would save life* but amputation of the toe; and we only call attention here to three facts: the quantity of chloroform does not seem to have been measured; it was administered by an unqualified person, without using any apparatus for determining the proportion of chloroform in the inspired air; it was employed for a minor operation. The second case is that of Pierre Pelletier, aged thirty-three, the subject of fistula. His physician had examined the head and heart prior to causing chloroform to be administered, and found nothing to create doubt. However, the patient died under chloroform. Mr. Gant, of the Royal Free Hospital, found the heart and lungs extensively diseased; the disease of the heart is described as "atrophy." Mr. Gant commented, apparently with some severity, on the mode of administration, and the laxity of the prior examination of the deceased. The physician, however, appeared to have taken most of the usual precautions, and he was properly acquitted of all criminal implication in the death of the patient. But here, too, it is proper to point out that the chloroform does not appear to have been given in measured quantity, that no apparatus was employed for regulating the admixture of air, and that the operation was one of a minor character. These conditions have now been found concurrent in so very large a proportion of fatal cases, that we cannot but continue to attach to them the importance which we have always maintained to belong to them.

Some dozens of lives have now been sacrificed by the administration of chloroform for the extraction of teeth, the removal of superficial sebaceous tumours, amputation of toes and fingers, and other trifling operations. Although Dr. Holland went to the extreme point of saying that he considered from the first that nothing could save his patient's life but amputation of the toe, yet it may be properly assumed that the affections mentioned do not involve issues of life and death. Moreover, we would point out that the facilities for procuring local anæsthesia are too much neglected in these cases. The removal of superficial tumours, the evulsion of nails, and the incision of abscesses, may be performed with the most complete absence of pain if the part be previously refrigerated by the well known mixture of ice and salt. The most painful of minor operations is the evulsion of the great toe-nail. Mr. Ernest Hart recently stated at the Medical Society of London that he had more than once performed this operation with the aid of the freezing process, the patient being completely unconscious of pain. It is sometimes complained that this process is tedious in its application; but to insure rapidity, it is only necessary that the ice should be very finely powdered, or, what is better, flaked with the end of a knife or cucumber-slice. It has lately been stated that the local application of chloroform in a particular manner, which we recently described, causes anæsthesia of the part; the application of compresses steeped in solutions of aconite has produced the same effect. The more general application of local anæsthesia is a means of diminishing that considerable mortality from the use of chloroform which must justly increase the growing fear with which the profession and the public regard that useful and beneficial agent. There are some features in many of the cases ending fatally which seem to show that a false security has been engendered as to the use of this agent. Dentists, druggists, and practitioners of but limited experience, are found administering chloroform under very trivial inducements, and omitting those precautions with which some of the most experienced and accustomed chloroformists would not venture to dispense. No prior examination, or a very imperfect one, is made; the chloroform is not measured; no apparatus is used; the admission of air is regulated by a rule of thumb; the pulse and respiration are not systematically watched and noted; and death occurs. It is highly desirable that a stricter *régime* should prevail, and that the administration of chloroform should not be thought or spoken of, or practised as a light matter. We protest against its employment where local anæsthesia may be substituted, where unskilled persons are the agents, where proper examinations and watchful supervision are not instituted, where provision is not made for its careful measurement and the regulated admission of 95 per cent. of atmospheric air, and where means of resuscitation are not apparently provided. The frequent recurrence of deaths by chloroform is a veritable misfortune to humanity and to science; it is one against which we are bound to employ all the care and forethought which are applicable to its prevention.—*Lancet.*

Chicago City Hospital.—The building was erected by the city at a cost of seventy-five thousand dollars. It is pleasantly located, its wards are spacious, and the arrangements for ventilation and bathing are perfect. It contains a Medical, Surgical, and Obstetric Department; also a special department for the Eye and Ear. Private patients may occupy separate apartments, and will be admitted from any part of the county by paying from $3 to $5 per week for board, washing, nursing, and medical attendance. Ephraim Ingalls, M.D., and Joseph P. Ross, M.D., *Physicians.* Joseph W. Freer, M.D., and Geo. K. Amerman, M.D., *Surgeons.*

American Medical Times.

SATURDAY, AUGUST 23, 1862.

MEDICAL MEN IN COURTS OF LAW.

The value of medical evidence in questions involving the causes and nature of deaths by unknown means has now been recognised nearly three centuries and a half. During this long period it has frequently demonstrated its accuracy of investigation of the subtile forces which destroyed life, and led with unerring certainty to the detection of the criminal or the exculpation of the innocent. In this field of research no other class of scientific experts can supersede the medical witness. His conclusions are based on an accurate knowledge of physiology, pathology, anatomy, chemistry, and the physical sciences, together with those attendant circumstances which are open to the observation of every one. The special knowledge which the medical witness is supposed to have, gives him the position of a skilled person, or one who is capable of deciding questions beyond the comprehension of ordinary witnesses. The position of the medical witness therefore becomes one of great importance to the cause of justice and truth, as well as of great responsibility. The courts of law are accustomed to accord to his testimony great value, and to regard his opinions with the most profound respect. To sustain well the high character of the medical expert in courts is not a trivial undertaking. In the first place, no small amount of knowledge of the medical sciences in general, is requisite to cope with the abstruse and obscure questions to which medico-legal questions give rise. There was a time indeed when surgeons only were allowed to testify as to the wounds of murdered persons in English courts, but that period has passed, and to-day the medical witness is expected to bring to the stand the most profound knowledge of his profession in all its departments of scientific investigation. In the second place, he must be an acute and logical reasoner in order to place the facts which he has drawn from science and from the surrounding circumstances in such harmony of relation, as to make an unbroken chain of logical sequences. We might add as a third qualification, and which is the most important of all in the interest of justice—a perfectly disinterested mind, devoted only to the discovery of the truth.

We have frequent and painful proofs that medical men do not always appreciate the responsible and truly dignified position which they are called to fill in courts of justice. Forgetful that they are presumed to be experts, or persons whose scientific attainments give their opinions great weight, and above all that they are unbiassed by any circumstance connected with the case, except positive and unquestioned facts, too frequently the medical witness takes the stand, an avowed partisan, and shapes his evidence to sustain some personal interest or preconceived notion. Nearly all the cases of trials for alleged mal-practice have their incipiency in the malicious suggestions of a medical man, who subsequently comes upon the witness-stand as an expert in settling the many questions in which he has a personal interest. The position of such a witness is unenviable in the extreme. He is unworthy the name and association which give him such power for evil, and should be discountenanced by every means which we possess in our individual or organized capacity. The injury which such men inflict upon their brethren is incalculable; many are made to incur heavy expenses, others are mulcted in damages, which afterwards hang heavily upon their resources, while a few are discouraged and driven from the profession. It is the duty of local societies to make stringent regulations in regard to that class of physicians who incite a prosecution for mal-practice. The case should be investigated rigidly, and if the evidence convicts, the name of the guilty party should be stricken from the membership of every medical organization.

Important as is the position of the medical man in courts of law, when upon his opinion rests the fair fame of a brother practitioner, it bears no comparison to those cases in which the life of an individual is trembling in the balance. The responsibility which falls upon the medical witness in trials of suspected murder, is more weighty than that which occurs in any other relation of life. He assumes, indeed, to determine with more accuracy than can any other witness who did not actually see the act committed, the nature and causes of the death. His opinion is based upon an analysis of facts, often extremely subtile, and generally susceptible of various explanations. How important that his mind should be entirely free from all preconceived theories, and that he should be uninfluenced by position or prejudice. And yet we have occasional instances of medical witnesses exhibiting a degree of feeling altogether incompatible with that dispassionate search after truth, which should characterize the expert.

Medical witnesses, also, occasionally seem forgetful of or at least disregard professional courtesy, and manifest towards the opinions of their brethren a degree of contempt quite unworthy of their high position. In the history of a recent murder trial in this State, we have a melancholy example of the rancor which one medical witness may exhibit towards another, growing out of a mere difference of opinion. Accusations of dishonesty, falsehood, and sinister motives are as unqualifiedly made against a member of the profession of irreproachable character and of the highest respectability, but a differing witness in the case, as if the parties were in a common street brawl. One witness taunts another with being paid for his services, as though that were a crime, and at the same time announces that he himself received nothing, as though that were a virtue, and gave greater impartiality to his opinion. Every physician who resorts to such unworthy and unprofessional means in a court of law, only degrades himself.

We could wish that in this country, at least, the medical profession would study more thoroughly forensic medicine, and come to appreciate the true dignity of a medical witness. The courts accord us the highest position in the scale of evidence, and it is exceedingly important that we do not abuse or lessen their confidence.

THE WEEK.

The medical inspection of enlisted men is, as far as we can learn, a most shallow farce. Under the pressure of a per caput fee, the inspecting officer aims to increase the numbers which he daily passes to the largest possible extent.

A single inspector has been known to examine two hundred and fifty persons in eight hours; thus giving less than two minutes to each. It is notorious that the troops from the State of New York, of the regiments sent out last year, had every manner of disability. Even cases with double hernia of large size, were endorsed by the inspecting officer. These abuses should be promptly corrected. It has recently been announced that Dr. CHARLES MCMILLAN, formerly Medical Director of General PORTER'S Division, army of the Potomac, has been assigned to duty on Governor MORGAN'S staff. We hope it will come within the duties of this officer, who is thoroughly familiar with the wants of the service, to reform the system of medical inspection which is now rapidly filling the army with worthless soldiers.

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GREAT attention has recently been given to the issue of consanguineous marriages, principally from the interest which the paper on this subject in the Transactions of the American Medical Association excited. Similar investigations have been made in England and in France. The last which we have met with is by M. BOUDIN. The following conclusions will prove of interest:

"That these marriages in France are about 2 per cent. of the whole of the marriages of the country; that the proportion of the born deaf and dumb issuing from marriages of consanguinity is, in relation to the whole number of born deaf and dumb, at least 25 per cent. at Lyons, 28 per cent. in Paris, and 30 per cent. in Bordeaux; that the proportion of born deaf and dumb increases with the degree of consanguinity of the parents. If 1 represents the danger of producing a deaf and dumb child in an ordinary marriage, the danger is 18 in the marriages of cousin-germans, 37 in the marriages of uncles and nieces, and 70 in those of nephews and aunts. At Berlin, 1 deaf and dumb is found among every 10,000 Catholics, 6 in every 10,000 Protestants, and 27 in every 10,000 Jews. In other words, the proportion of deaf and dumb increases with the facility accorded by different forms of worship to unions of consanguinity."

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THE practice of extirpating a diseased eye to preserve a healthy one is disapproved of by Sichel, the French oculist. The following are stated to be his views:

"With regard to the extirpation of a diseased eye, practised for the purpose of preserving the sound one, M. Sichel says that it is an operation which has been greatly abused of late. It is undoubtedly true that a disease in one eye may at last affect the healthy eye; but affections of this nature very often depend upon constitutional causes; and, when this is the case, it happens that the healthy eye becomes at last affected as the result of the diseased constitutional conditions. The extirpation of the eye primitively affected cannot in any way cut short the influence of these constitutional causes upon the healthy eye. The general affection of the body was the original cause of the ocular disease, and is also the cause which keeps up the disease; and the right treatment, therefore, for the preservation of the healthy eye, is to attack by therapeutics the general affection. M. Sichel also remarked, that his observations of the good effects of general treatment in diseases of the eye had often led him to combat the too frequent tendency to surgical operations in these diseases."

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A CASE was recently tried in England, involving the question of the proper disposition of the "dissected fragments of humanity, as they pass from the schools to the burial-ground." The law requires that the bodies of dissected persons shall be "decently interred in consecrated ground." Counsel contended that "inasmuch as the burial service was intended as a solemn rite for the consolation and benefit of the living, its performance in the absence of all witnesses over the decayed fragments of a dissected body was improper and unbecoming." The judge, however, overruled this opinion, and decided that the remains "should have the burial service read over them."

Reviews.

THE CHICAGO SANITARY COMMISSION. Second Report. Chicago: 1862.

FROM the second report of this Commission we have most gratifying evidence of the success which has attended its efforts to distribute the charities of the people among the sick and wounded. The following extracts will give some insight into its operations:—

"FINANCIAL STATEMENT.—It will suffice to state in this place, that the receipts in money during five months have been $12 434,43, of which $5,000 were contributed by the Common Council of the City of Chicago from the public funds, and $2,000 by the Chicago Board of Trade from its Treasury. Not a few individuals have also given liberally, some from their wealth and others from their poverty. The expenditures for the same time have been $10.702,74."

"TO WHAT PLACES SENT.—We have sent, during the past five months, 1427 boxes and packages of goods from our rooms in Chicago, many of which were valuable medicinal stores, purchased in this city by the Commission, to supplement important deficiencies in the supplies of the United States. The distribution has been to the hospitals and camps at and near Cairo, Paducah, Pittsburg Landing, Hamburg, Savannah, and Corinth, and also to a small extent to Missouri."

"NO DISTINCTION MADE AS TO TROOPS.—Some have supposed that the Commission have been partial to the troops from Illinois in the appropriation of the supplies furnished; but the apprehension is quite unfounded. We never inquire after the State from which the suffering soldiers come, but aid all who are on our field of operations in the army of the West. We have received liberal supplies from Wisconsin, Michigan, and Indiana, as well as from our own State, and we have made corresponding use of our stores, both in supplying regimental and post hospitals, and the General Hospital at Mound City, and in furnishing the boats detailed to transport the sick and wounded. Twice we fitted out (at an expense of *one thousand dollars*, on each occasion, for *medicinal supplies simply*, in addition to boxes of clothing, &c.), steamboats sent for the purpose of bringing home Illinois soldiers, by our Governor; but the money was contributed for that express purpose by the Chicago Board of Trade. We did a similar act out of our general funds, for the boat sent by the Governor of the State of Wisconsin. We tendered similar aid to the Governor of Michigan by a letter, to which no answer was received."

"ENLARGEMENT OF OPERATIONS.—Mr. Thomas P. Robb observes in his report—The amount of supplies shipped up the Tennessee river has been truly wonderful, and it gives me great pleasure to inform you that your Commission and the State of Illinois stand at the head of the list. The shipments of the Chicago Sanitary Commission have been more than double any other Society of the kind, and most certainly no other State officers have used the same untiring efforts, as those of Gov. Yates, Col. Moses, and Secretary Hatch, in behalf of the sick and wounded. Great care is taken by Drs. Douglas and Grimsted, that all requisitions are faithfully and properly applied, and in no instance do they fill requisitions with articles not needed by the sick and wounded. Since the battle of Shiloh, I have known the weekly distribution of Sanitary Stores to run as high as five thousand dollars."

"SOLDIERS' HOME AND DEPOT OF SUPPLIES AT CAIRO.—To no result of our labors during the past five months, can we point with greater satisfaction than to the establishment, at the suggestion of Dr. J. H. Douglas, of the U. S. Sanitary Commission, of the Soldiers' Home at Cairo, for the brief entertainment of the poor fellows who arrive at that point from the army, and have no means of procuring food and lodging. Weak and ill

in body, discouraged and despondent in mind, strangers to the place and people, destitute of money, though often creditors of the Government, they need some roof to shelter them, and some friend to secure the papers necessary for their discharge or their journey home. At our request, the Government provided a building and the usual army rations, and we have placed there a Superintendent and an Assistant, to act as a guardian to the men in all the respects in which they need advice or aid. About fifty soldiers slept there, on an average, every night, though occasionally as many as one hundred and thirty have been accommodated. These have usually departed in the morning train with cheerful and grateful hearts. The entire number thus aided has been about *three thousand!*"

Is Tracheotomy in True Croup a Justifiable Operation. By John O'Reilly, M.D., Licentiate and Fellow of the Royal College of Surgeons in Ireland: Resident Fellow of the New York Academy of Medicine; Member of the Medico-Chirurgical College of New York. pp. 23.

Dr. O'Reilly entertains novel views of the causes of croup. He contends that it depends upon a specific poison as much as intermittent fever or small-pox, and should be treated by such remedies as will tend to neutralize the poison and eliminate it from the system, combined with tonics. His remedies are ipecac to unload the stomach and remove irritation; calomel to increase the secretion of bile, and clean out the intestines; quinine to strengthen the organic nervous system and neutralize and overpower the poison; and sulphate of potash to convert the albumen into mucus. The following are his views of tracheotomy and the use of chloroform:—

"I have further to protest against the operation of tracheotomy in true croup, on the following grounds:

"*Firstly.* That the operation cannot be productive of advantage, inasmuch as the air cannot be brought in contact with the sound part of the lungs in consequence of the diseased action of the organic glands, which have thrown out a false membrane in the trachea and bronchi, and a similar substance to the false membrane in the air-cells, which thus *throws* up a *blockade against the contact of the air with the pulmonary glands.*

"*Secondly.* That there is *primâ facie* evidence that the operation is useless, inasmuch as the patient dies *after the operation* at certain intervals, as before stated.

"*Thirdly.* That it is well established, that in cases suitable for the operation of tracheotomy, such as foreign bodies in the trachea, idiopathic or specific laryngitis, secondary croup, there is very little danger to be apprehended from the operation: it therefore follows that the great mortality attendant on the operation for true croup, must be the consequence of some other difficulty in addition to the impediment presented by the false membrane to the entrance of air into the lungs; the truth is, the patient dies from exhaustion of the organic nervous system and want of oxygen, when death takes place after the operation.

"It has been stated that some of the patients on whom the operation has been performed, have been put under the influence of chloroform, and that there was very little difficulty experienced in producing insensibility. Having protested against the operation of tracheotomy in true croup, I cannot find language sufficiently strong to protest against the administration of chloroform to a child suffering from true croup."

The Physician's Visiting List, Diary and Book of Engagements for 1863: Philadelphia. Lindsay & Blakiston.

This is a very convenient book for the practitioner, containing all the details which he may require in compact form.

The Half-Yearly Abstract of the Medical Sciences: Edited by W. H. Ranking, M.D., and C. B. Radcliffe, M.D., No. 35, January to July, 1862. Philadelphia: Lindsay & Blakiston.

Half-Yearly Retrospect of Practical Medicine, Surgery, and Obstetrics. By W. Braithwaite. New York: W. A. Townsend.

These semi-annual publications are filled with the gleanings of practical matter from the various medical journals. Every physician should subscribe to these works.

Correspondence.

HOSPITALS AT NASHVILLE, TENN.

[To the Editor of the American Medical Times.]

University Hospital, Nos. 2 and 3.
Nashville, Tenn., Aug. 6, 1862.

Sir:—I append a copy of the reports of the number of sick and wounded who have been under treatment during the past five months in the General Hospitals, Nos. 2 and 3, under the direction of Surgeon A. Henry Thurston, U. S. V. The report for March covers only the cases under treatment during the three weeks following the tenth of the month, as previous to that date everything was in a chaotic state of transition. Before the surrender of Nashville, the two large buildings of the University of Nashville were occupied by sick and wounded soldiers from the ranks of the Confederate Army. A large supply of hospital stores had also been accumulated on the premises. But during the panic which was occasioned by the capture of Fort Donelson, about the 20th of February, the number of patients which at one time had been not less than twelve hundred, was rapidly diminished, so that only the most wretched and helpless were left, to hail the coming of our surgeons. The medical stores were depleted in a similar manner, and the University Hospital presented an appearance in no way calculated to inspire its inmates with hopes of recovery. This was a condition of affairs which grew worse every day till about the 8th of March, when surgeon Thurston was placed in charge. He found seven hundred sick and wounded men, the majority of them from the ranks of Gen. Buell's army, shivering in the uncleaned wards and halls of the two buildings under his direction. Fuel, food, and medical attendance were first supplied. Cleanliness, order, and discipline speedily followed; and the number of patients for whom suitable accommodations could not be furnished, was diminished as rapidly as possible. In less than two weeks Dr. Thurston presided over a hospital which in every respect of situation, provision, and resources requisite for the successful treatment and comfort of patients, was unrivalled by any other military hospital in the Western Department.

The University Hospital is remarkably fortunate in its situation, since it occupies the building and grounds of the Academic Department of the Nashville University, upon a hill in the southern suburb of the city, about one mile and a half distant from the capitol. The two buildings which were formerly devoted to the barracks and recitation rooms of the students in the Military School, now offer accommodations for five hundred patients. There is also within the same inclosure a large house in which the professors formerly resided. To this were attached the cook-house, the dining hall, the washrooms, and the engine-house of the University. The operations of this establishment are continued without change, only it must be confessed that the apartments of the fugitive faculty are occupied by Dr. Thurston and his staff of assistant surgeons, while the dining hall is three times daily thronged with convalescent United States Volunteers, who fill the places once consecrated to the use of the Nashville cadets. A convenient house for the deposit of the dead has been erected, and various other improvements have been introduced, so that the institution is now quite complete. A fence surrounds the grounds, inclosing sixteen acres of grass-plot, affording to the convalescent patients an opportunity for exercise out of doors without exposure to the temptations and injurious influences which assail the invalid soldier who is compelled to seek the open air in the streets of a city.

Of the two buildings which are devoted to the accom-

modation of patients, one (Hospital No. 2) is a large two-story structure, well built of limestone, arranged in the form of a cross. The quondam recitation rooms and halls afford space for thirteen wards, all large, airy, and well lighted. Smaller rooms under the same roof have been fitted with conveniences for bathing, and for the use of the subordinate officers of the hospital. The edifice known as Hospital No. 3 is located about one hundred yards behind No. 2. It is a three-story brick building, with central halls, which longitudinally divide each floor, and give access to twenty-five small apartments that were used as lodging-room for the students. Each of these cells is entered through one doorway, is lighted by one window, and contains five beds. To prevent any stagnation of the air in these narrow wards, the doors have been removed from their hinges, so that every patient can take advantage of the fresh air which is continually circulating through the wide entries and central passage-ways, an arrangement which insures a degree of ventilation more complete than is possible in many hospitals whose plan is more complicated and pretentious. The privies are removed to a distance of one hundred yards from the building: a circumstance which in this mild climate seldom occasions any inconvenience to those patients who are able to leave their beds. The diet of the patients is excellent. There is an abundance of milk, beef, bread, rice, and vegetables, all of the very best quality. Beef-tea, soup, and ice are supplied without stint. Besides all this, the pockets of the patients are generally so well lined with the coin and the notes of the United States that, while the comforts of many are generally increased, it is impossible to obviate that tendency to repeated attacks of cholera morbus which is a feature so remarkably characteristic of the convalescence of our more juvenile warriors.

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Sectio Cadaveris.—July 27th, 3 o'clock P.M., five hours after death. Rigor mortis had not supervened; the whole body was warm, and the skin was yet moist. The livid color had disappeared, excepting from the lips and nose, and from the depending portions of the body. The frame was compact, muscular, and well clothed with adipose tissue.

Cranium.—The arachnoid was raised by a considerable serous effusion. At the base of the brain were not less than four ounces of fluid. There was no unusual congestion of the pia mater, or of the substance of the brain, nor was the amount of fluid in the ventricles perceptibly increased. The grey matter was very little, if at all darker than usual; the lower surface of the middle lobes was much softened.

Thorax.—The lungs were perfectly healthy: the pleural investment of the right lung was bound by old adhesions to the costal pleura. Very little fluid in the left pleural cavity. The heart was healthy: its left ventricle was

firmly contracted and empty; the right ventricle contained a small white clot; the right auricle was immensely distended with black, fluid blood. The pericardium contained about five ounces of clear, serous fluid.

Abdomen.—The intestines were uninflated: their only contents were a thin, pasty, straw-colored fluid, very scanty in amount. The external surface of the duodenum and jejunum presented a beautiful pinkish hue: the ileum and the colon were more darkly congested. The mucous membrane of the entire alimentary canal presented no sign of pre-existent disease, unless the solitary glands of the cœcum were larger and more conspicuous than is usual; several of them were near the size of a mustard seed. The spleen was not enlarged: it was of a slate-colored, and its substance was as firm as that of the liver. The kidneys appeared to be healthy. There was no accumulation of fluid within the peritoneal cavity. The liver was full of blood, black, and fluent. Its color was a dark chocolate tint. The gall bladder was filled with liquid, yellowish-green bile. The blood was uncoagulated in the veins of the arm, as well as throughout the viscera.

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FOREIGN CORRESPONDENCE.

LETTER IX.

BY PROF. CHARLES A. LEE.

PUBLIC HEALTH—WATER SUPPLY AND METHODS OF FILTRATION—DISEASED MEAT.

LONDON, July 12, 1862.

THIS imperial city now extends over 122 square miles, numbering nearly 3,000,000 of inhabitants, and represents the civilization of the age. It also offers unrivalled advantages for the study of mankind, under singular circumstances. Its average annual mortality is a fraction over twenty-two in a thousand, and the recorded observations of the last twenty-three years have thrown great light upon the prevalent causes of disease; indeed, it has been well observed that the results are as valuable as an experimental philosopher could have deduced from his experiments, if he had had the power to expose the population to great vicissitudes of heat and cold, of dampness and dryness; to the changes incidental to differences in the prices of food; to air and water of different degrees of impurity; and to destructive epidemics. No fact is better established than that excessive heat and cold injure health, and increase the mortality, the first, by occasioning bowel complaints, the latter, diseases of the respiratory organs—the effect being much the greatest in infancy and old age, and varying with age at rates regulated by laws.

Water, as it forms the greatest portion of the human body, has been well called the life-blood of cities, and the lowest mortality range is only compatible with a high degree of purity of this element.

The water used for drink by the inhabitants of this city is derived from shallow wells, deep wells, New River, the river Thames, and its tributaries. The well water is very impure, and has a large amount of organic matter in solution derived from cess-pools. The Thames is the great sewer of London and the country adjacent. In 1849, when 14,125 persons were swept away by cholera, it supplied the south and west districts of London with drinking-water, containing large amounts of organic matter, and it was found that the rates of mortality by that disease bore a direct ratio to the impurity of the water used by the inhabitants. No more important fact, perhaps, has ever been established by registration, than that the liability to attack from epidemic cholera is in proportion to the quantity of decaying organic matter contained in the water drunk. This was so fully proved by a committee appointed by the Board of Health, to inquire into the deaths in every house supplied by the different water companies, that it has never since been disputed, and yet the quantity of organic matter in the Southwark water, which proved so deleterious, was only two grains in a gallon in excess of that in the Lambeth water, so that 15 in 10,000 died of cholera who drank of water taken high up from the Thames, at Kew and Hammersmith; 48 in 10,000 in districts supplied by tributaries of the Thames; and 123 in the same number supplied with water taken from the foul part of the Thames, between Battersea and Waterloo Bridge. The tributaries of London have, in fine, proved beyond all doubt, that water containing minute quantities of organic matter, as river water receiving the sewage of towns, or surface wells in cities, into which impurities will find their way, must often contain the elements of zymotic diseases, and can never be drunk with entire impurity. In other words, it is a truism, that the purest water is the healthiest. Government, acting on this well established fact, directs twelvemonthly analyses, by a skilful chemist, of the waters of each of the six companies which supply London with water, to be published in the Weekly Tables, so that the public constantly know, or have the means of knowing, what kind of water they are drinking. It would not be amiss to have a similar regulation adopted in regard to our New York Croton water, which is often loaded, in hot weather in summer, with organic matter, in the shape of infusoria, which increase, as is well known, with miraculous rapidity. This may be easily remedied now, as we have three reservoirs, by causing the water to be entirely drawn off from each, at certain intervals, during the summer and autumn, the city being in the mean time supplied from the others. There is no doubt in my mind that this cause contributes to the high death ratio in New York, especially among children; for the reduction of the mortality in London coincides very accurately with the improvement in the water supply. It is well known that the sewage of this city is, in general, very perfect, and no city in the world, so far as I know, is always kept in a cleaner condition. Hence it is not illogical to attribute the diminished mortality (22.49 in 1000 living in London, in 1860) to the improved water supply.

And this brings me to a subject which has been suggested by a late visit to the International Exhibition, viz. the various methods of filtration and other modes of purifying water there displayed. More than one hundred different patents have been taken out in England for the purification of water, and we often see beautiful fountains of curious devices fitted up in shop windows, where such apparatus is kept for sale. So far as I have been able to investigate the matter, *carbon*, in some form, is the agent generally employed, although there is scarcely a porous or tasteless substance in nature but what is put in requisition for this purpose. When charcoal is employed it is usually made solid by compression, as the finer the pores the more perfect the filtration, as is supposed. But there is always this difficulty, that the pores in a hard mass must unavoidably become more or less clogged in a short time, and there is no way of cleansing them. This objection must always,

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LETTER IX.

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as it seems to me, apply to filters made of consolidated charcoal; granules of animal charcoal, it is well known, offer an equally effectual resistance to impurities, and filters composed of it can be readily cleaned by simple rinsing. Still, filters made of solid masses of silicated charcoal, silex being employed to give shape and consistence, are now very popular in London, and are in constant use in the royal household, and most houses of the nobility and gentry. The silex usually employed is a refuse of gas-works; formerly some bituminous compounds were used to bind the carboniferous particles together—many prefer filters made of loose particles of charcoal, in grains about the size of gunpowder, regarding silex, pitch, or any other substance to bind the particles together as having no advantage whatever, and being simply an adulteration. Such are Danchell's filters, while Messrs. Dahlhe, Atkins, and others are the solid blocks. A popular error in regard to water needs correction, and that is, that water containing deleterious matter must necessarily be foul in appearance; whereas some of the wells in London, which yield apparently the clearest, brightest, and most translucent water I ever saw, are absolutely so loaded with organic matter as to be poisonous, and no filtration will correct the evil. Whatever the impregnations may be, they are not removed by carbon filters; nor will any of these one hundred filters remove any of the salts of lime held in solution—not even the phosphates of the graveyards and cemeteries. It is well that we have such infallible chemical tests for these and other mineral salts and substances.

One highly original plan of filtration by Mr. Spencer deserves special notice, and that is, the *magnetic* system of purifying water, which has now been adopted in the public supply of several large towns. This is the same gentleman who discovered electro-metallurgy, and I believe that he confidently claims for his system, that it will separate all mineral and organic matters whatever from water. That it may readily separate all ferruginous matters I can readily understand; but on what principle it removes salts of lime, or other minerals, is not very easy to comprehend.

In my visits to the various markets in London, and especially to those narrow, dark streets, where meat is sold to the poorest classes, I have been greatly surprised to see the great quantities of diseased meat allowed to be sold. I have seen, within sound of Bow Bells, more diseased meat offered for sale during the last two months, than I ever saw in New York during my whole life. Indeed, such samples of flesh meat, I venture to say, could hardly be found beyond the precincts of this city; and that notwithstanding there are plenty of Health Officers and Inspectors. Generally it sells as low as a penny per pound, and it is fearful to think what quantities of it must be consumed by the poorer classes. It is especially patronized by the sausage-makers, soup shops, and beef and meat pie shops. Such meat is sent here from all parts of the country, even from a distance of 150 miles, or more; and some Insurance offices exist in London, who insure cattle and sheep on condition that if the animals die from diseases, they shall belong to the Company, "the party insuring receiving two-thirds the value of the animal, and one-third the salvage; or, in other words, one-third of the amount the beast is sold for when dead." And those Insurance offices have their own slaughter-houses, where such animals are killed and dressed. Nearly 5000 lbs. of such meat have been recently seized in this city in one week, and yet the trade flourishes. It has been ascertained also that a considerable portion of this diseased meat comes from urban cow-houses—a pest quite as common here as in New York. The contagious pleuro-pneumonia, which has recently proved so fatal to cattle in New England, has prevailed extensively in England of late years, and is the most fatal of all diseases affecting ruminant animals. It has recently been shown, that within the last few years this disease has prevailed more or less in every dairy in the city, and that probably *in all cases*, cows sick or dying of it, have been sold to the butchers. This contagious lung disease has extended to most of the grazing districts of the island, affecting sheep as well as cattle; and as soon as an animal gives any signs of an attack, it is slaughtered and sent to London, or some of the great towns. The disease, however, is said, by veterinary practitioners, to be more ripe among London dairy stock than elsewhere, owing to the over-crowded, ill-ventilated, and filthy cow-sheds. The obvious remedy for this evil is, the abolition of private slaughter-houses, and the erection of public *abattoirs*, as in Paris. No animal should be allowed to be privately killed and dressed; and this should be extended to the whole kingdom. The great multiplication of private slaughter-houses in New York furnishes extensive facilities for the sale of diseased meat; and the immense number of cows kept in close stables, and fed on distillery slops, furnish strong temptations to their owners to make their carcasses profitable, as well as their milk, even when dying of disease. Perhaps closer investigation in regard to this matter may lead to the discovery of evils whose existence is hardly suspected. However this may be, there must exist some powerful special causes of sickness and death, of far wider scope and greater intensity than are found in London, to account for the much higher death rate than prevails here, or in any of the large cities of Great Britain, or even of Europe.

Medical News.

Chromhidrose.—Several medical men, as our readers may remember, have given in their belief in the existence of a malady called cromhidrose. M. Behier, in the name of a commission appointed to investigate the case of the female at Brest presented by M. de Mericourt as a subject of the affection, has sent in a report. This report points out the way in which medical and other believers have been deceived. The black coloring matter used by the feminine adepts appears to have been chiefly of a sooty kind. When the coloring matter was removed from the eyelids, the discoloration was reproduced by vigorous winking. It never returned *suâ sponte*. A supply of the coloring matter was found at the base of the eyelashes, agglutinated around the hairs. By the use of the kohenit—a dark cosmetic applied to the eyelashes—and by winking, the chromhidrose was produced in a few minutes. M. Robin, on analysis of the dark matter, stated that it was a substance *sui generis*, and of the nature of the coloring matter of the choroid, and was mixed up with fatty matter and cells. But this *sui generis* matter turns out to be the epidermic cells, and removed with the coloring matter when scratched off the eyelids. M. Gubler of Liege has put a finishing stroke to the business, by showing that, in one young lady suffering under chromhidrosis, the coloring matter was found spread over the *external* surface of a layer of collodion laid upon the eyelids!—*Brit. Jour.*

Dr. Sloan and our Sick and Wounded Men.—All the military hospitals in this city, including the Ladies' Hospital—the City Hospital—Bellevue Hospital—St. Luke's Hospital—the Jews' Hospital—the two hospitals in Brooklyn, and the hospitals on David's Island, Bedloe's Island, Blackwell's Island, and Governor's Island—containing nearly five thousand sick and wounded soldiers, are under the charge of Dr. Sloan, the Medical Director, whose appointment reflects great credit on the foresight and sagacity of Surgeon-General Hammond. Dr. Sloan has been a surgeon in the army for the last quarter of a century, and his professional skill, and great executive ability, have won for him the confidence of the community and the Government. Dr. Sloan is a gentleman of culture and experience, and he has been at work noiselessly, bringing order out of chaos, and reducing to perfect system the business in his hands.—*Paper.*

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 11th day of August to the 18th day of August, 1862.

Deaths.—Men, 164; women, 117; boys, 205; girls, 199—total, 685. Adults, 281; children, 404; males, 349; females, 316; colored, 4. Infants under two years of age, 341. Children reported of native parents, 23; foreign, 391.

Among the causes of death we notice:—Apoplexy, 11; infantile convulsions, 49; croup, 4; diphtheria, 8; scarlet fever, 5; typhus and typhoid fevers, 19; consumption, 65; small-pox, 4; measles, 6; dropsy of head, 30; infantile marasmus, 42; cholera infantum, 153; cholera morbus, 8; congestion of brain, 24; inflammation of brain, 15; of bowels, 25; of lungs, 6; whooping cough, 6; bronchitis, 6; congestion of brain, 24; of lungs, 6; erysipelas, 1; diarrhœa and dysentery, 34; sun-stroke, 35. 458 deaths occurred from acute disease, and 38 from violent causes. 454 were native, and 231 foreign; of whom 155 came from Ireland; 88 died in the City Charities; of whom 24 were in the Bellevue Hospital, and 11 died in the Emigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Aug. 1862	Barometer. Mean height.	Barometer. Daily range.	Temperature. Mean	Temperature. Min.	Temperature. Max.	Difference of dry and wet bulb. Thrm. Mean	Difference of dry and wet bulb. Thrm. Max.	Wind.	Mean amount of cloud.	Humidity Saturation, 1000
	In.	In.	°	°	°	°	°			
10th.	29 84	.14	77	72	85	10	16	W.	.04	570
11th.	29 94	.20	77	68	87	9	18	S.	1	600
12th.	29.90	.20	78	67	91	9	11	NW to SW	3	610
13th.	30.10	.20	72	64	80	12⅛	18	NW to SW	.05	406
14th.	30.00	.21	71	64	78	11⅛	16	S. W.	.04	420
15th.	29 87	.20	73	68	82	11	14	W.	2	460
16th.	30.07	.21	65	56	75	12	16	N. W.	.04	400

Remarks.—10th, Clear; wind fresh at midday. 11th, Mostly clear; wind fresh most of the day. 12th, Variable; very sultry at noon; thunder shower at 1½ P.M., with a quarter inch of rain. 13th, Clear; fresh wind A.M. 14th, Clear; fresh wind P.M. 15th, Clear, fresh wind P.M. and cloudy. 16th, Fine day, with fresh breezes. The last four days were very dry.

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To the Medical Profession.—Dr. I.

Parigot has changed his residence and is prepared to receive a very limited number of patients in his country house at Hastings, on the Hudson; he can be consulted in town at Dr. Douglas' Office, No. 12 Clinton Place, on Tuesdays and Saturdays, for Nervous Diseases and Medico-Legal questions.

Wm. H. Davol, M.D., late Physician

to L. I. College Hospital, Brooklyn, removed to St. Paul, Minn.

References.—C. L. Mitchell, M.D., T. L. Mason, M.D., Prof. E. N. Chapman, M.D., of Brooklyn; Prof. Austin Flint, M.D., Prof. B. F. Barker, M.D., of New York.

On the Various Contrivances by

which British and Foreign Orchids are fertilized by Insects, and on the good effects of Intercrossing. By Charles Darwin, M.A., F.R.S., etc. 8vo. London, 1862. $2.80.

Baillière Brothers, 440 Broadway, N. Y.

Gmelin (L.) Hand-Book of Chemistry.

Vol. I. 2d Edition, revised. 8vo. London, 1861. $3.25.

Baillière Brothers, 440 Broadway, N. Y.

An Inquiry into the Medicinal Value

of the Excreta of Reptiles in Phthisis and some other Diseases, by J. Hastings, M.D. London, 1862. $1.50.

Baillière Brothers, 440 Broadway, N. Y.

The Pathology and Treatment of

Phlegmasia Dolens, as Deduced from Clinical and Physiological Researches. By F. W. Mackenzie, M.D. 8vo. London, 1862. $1.87.

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B. I. RAPHAEL, M.D., Professor of the Principles and Practice of Surgery.
CHARLES A. BUDD, M.D., Professor of the Theory and Practice of Midwifery.
A. JACOBI, M.D., Professor of Infantile Pathology and Therapeutics.
E. NOEGGERATH, M.D., Professor of Clinical Midwifery and Diseases of Women.
J. V. C. SMITH, M.D., Professor of Anatomy.
WM. F. HOLCOMB, M.D., Professor of Ophthalmic and Aural Surgery.
SAMUEL R. PERCY, M.D., Professor of Materia Medica and Therapeutics.
HENRY G. COX, M.D., Professor of Theory and Practice and Clinical Medicine.
CHARLES A. SEELY, Professor of Chemistry and Toxicology.
HON. JOHN H. ANTHON, A.M., Professor of Medical Jurisprudence.
——— Professor of Physiology of Microscopic Anatomy.*
JAMES E. STEELE, M.D., Demonstrator of Anatomy and Curator of the Museum.
GEORGE WOOD JEWETT, M.D., Assistant to the Professor of Midwifery.
WM. BALSER, M.D., Assistant to the Professor of Infantile Pathology.
F. S. SNEADE, Janitor.

A preliminary term will commence on Monday, September 15th, and continue until the Regular term begins. This Course will be GRATIS to those students who intend taking a full winter Course, and will be as follows:—

On Amputations, by.....Prof. Carnochan.
" Gunshot Wounds, by.....Prof. Raphael.
" Pregnancy, by.....Prof. Budd.
" Anatomy and Physiology of the New Born, by.....Prof. Jacobi.
" Bandaging, by.....Prof. Holcomb.
" Anatomy of the Regions, by.....Prof. Smith.

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Dean of the Faculty, 91 Ninth Street.

* Prof. Browne having received the appointment of Brigade Surgeon, has resigned the chair of Physiology. The chair is now vacant, but will be filled before the commencement of the Course.

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Bertheraud. Campagnes de Kabylie. Histoire Medico-Chirurgicale des Expeditions de 1854, 1856, and 1857. 8vo. Paris, 1862. $1.80.

Boudin.—Resumes des dispositions legales et reglementaires qui president aux operations medicales du recrutement, de la reforme et de la retraite dans l'armée de terre. 8vo. Paris. 50 cts.

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Cazalas. Maladies de l'Armee d'Orient. Campagne de 1854-55-56. 8vo. Paris, 1860. $1.25.

Fraser. A Treatise upon Penetrating Wounds of the Chest. 8vo. London, 1859. $1.60.

Guthrie.—Commentaries on the Sur-GERY OF THE WAR IN PORTUGAL, SPAIN, FRANCE, and the NETHERLANDS. With Additions relating to the War in the Crimea. 8vo. London. $4.65.

Jacquot. Du Typhus de l'Armee d'Orient. 8vo. Paris, 1858. $1.87.

Longmore (T.) A Treatise on Gunshot WOUNDS. Philadelphia, 1862. 75 cts.

Tripler & Blackman.—Hand-Book for THE MILITARY SURGEON. 12mo. Cincinnati. $1.

Notes on the Surgery of the War in the Crimea, with Remarks on the Treatment of Gunshot Wounds. By GEORGE H. B. MACLEOD, M.D. Philadelphia, 1861. $1.50.

Outlines of Military Surgery. By SIR GEORGE BALLINGALL, M.D. 5th edition, 8vo. London. Price $4.00.

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